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Issue Date: 01 November 2002

In the Matter of

William Pearman,
Claimant

v.

Bethlehem Steel Corp.,
Employer/Self-Insured

Case No.: 2002-LHC-0512,513
OWCP No.: 04-31882
04-32896

DECISION AND ORDER
AWARDING BENEFITS

This proceeding involves a claim for benefits under the Longshore and Harbor Worker's Compensation Act, as amended, 33 USC § 901, et seq. (hereinafter LHWCA). A hearing was held before me in Baltimore, Maryland, on April 10, 2002, at which time the parties were given the opportunity to offer testimony and documentary evidence, and to make oral argument. At the hearing, Claimant's Exhibits 1 through 8, Employer's Exhibits 1 through 5, and ALJ Exhibits 1 through 7 were admitted into evidence. The Claimant's post-hearing brief was filed on June 20, 2002; the Employer's post-hearing brief was filed on June 18, 2002; and the Director's post-hearing brief was filed on July 15, 2002. I have reviewed and considered these briefs in making my determination in this matter.

I. Statement of the Case

Testimony of the Claimant

In May 1994, the Claimant was employed as a first class pipefitter for Bethlehem Steel, working on pipes, pulling hoses, and doing other activities associated with his job, which required the use of both of his hands. As a result of a 1992 injury to his left hand, he was on modified work in the pipe shop, fabricating and bending pipe, and cutting angles, with another man. The Claimant did this work for approximately three years (Tr. 21).

On the 5th or 6th of May 1994, the Claimant began to get a tingling and numbness in his left arm and hand, and he returned to Dr. Halikman, who subsequently performed surgery on his left elbow. Dr. Halikman then referred the Claimant to Dr. Dellon, who performed surgery to try to save the nerve in his left hand. However, he was unable to do so, and the Claimant was left with the use of only three fingers (Tr. 22). The Claimant last saw Dr. Dellon about one year earlier (Tr. 22). At that time, Dr. Dellon told him that he probably would not be able to go back to work as a pipefitter (Tr. 23). According to the Claimant, he had received a call from a Ms. Brenda Blue two or three years earlier, asking if he would like to come back to work at the pipes department, but he told her he was out on disability. Other than that, the Claimant has not been contacted by the Employer about returning to modified work (Tr. 23).

According to the Claimant, he has the use only of his thumb and a finger on his left hand. He is not able to do his work as a pipefitter (Tr. 23). He is 53 years of age, and has a seventh grade education (Tr. 23). He started working for the Employer in November of 1979, working his way up from handyman/helper to first class pipefitter (Tr. 24). As a pipefitter, the Claimant dismantled pipes on ships, fabricated pipes, and installed pipes on ships. According to the Claimant, pipes are replaced anywhere from the bow to the stern, 60 to 70 feet down. The pipefitters must climb up and down, carrying their tools, which weigh about 60 pounds. It is not the type of work that can be done with one hand (Tr. 25-26).

The Claimant testified that he is constantly in pain, but he does not take medication because earlier he became addicted to pain medication, and went through a very bad withdrawal. He would rather deal with his pain than get hooked on medication again. He described the pain as continuous, from his hand to his elbow. It is worse in the wintertime. He no longer plays baseball or football, because if he injures his remaining fingers, they may have to be removed (Tr. 27-28). The Claimant stated that he cannot open his fourth, third, or second fingers, which are in a clawed position. He wears a glove on his left hand, to remind him not to get it near anything hot, or slammed in a door. According to the Claimant, he now can feel his hand, but he cannot feel the three clawed fingers (Tr. 28). The Claimant testified that Dr. Dellon removed a nerve from his middle finger and rerouted it to his little finger, to keep him from burning or injuring his fingers (Tr. 29).

The Claimant testified that after his 1992 injury to his left hand, he also had right hand and elbow problems (Tr. 29-31). Dr. Halikman performed surgery on the Claimant's right hand and elbow, and subsequently, in 1994, the Claimant developed problems in his left elbow, similar to those he had in his right elbow (Tr. 31).

The Claimant had surgery and a fusion on his neck in April 1991 (Tr. 34). He was also under treatment for heart problems; he was a smoker, and suffered from shortness of breath (Tr. 35).

Eastern Industrial Medical Center

The Claimant was seen by Dr. Rodolfo E. Dollette at the Eastern Industrial Medical Center on May 15, 1992, for treatment of an injury to his left hand on May 13, 1992. He had pain and swelling on his left hand, and was unable to close his fist. He was diagnosed with contusion of the left hand, and given a hand splint (EX 3). He was placed on modified work, but did not keep his follow up appointment with Dr. Dollette.

The Claimant saw Dr. Arturo Pidlaoan on July 13, 1992, complaining of swelling and pain in his left hand. Dr. Pidlaoan found swelling on examination, and non-pitting edema, with vague tenderness. The Claimant had full mobility of his fingers. He advised the Claimant to stop using a splint, and to use gloves for protection.

The Claimant visited Dr. Pidlaoan again on July 28, 1992. Dr. Pidlaoan noted that the Claimant's left hand was still swollen and very touchy. The severe contusion was gone, but the Claimant had marked neuralgia or pain because of the healing effect. Dr. Pidlaoan prescribed warm soaks, massage, and exercise.

Dr. Sarshar examined the Claimant on August 17, 1992, noting that he had been doing light work. The Claimant had moderate chronic swelling and discoloration on the dorsal aspect of his left hand. His impression was that the Claimant had chronic edema of a post traumatic nature on the dorsal aspect of his left hand. Dr. Sarshar felt that he should only be treated with physical therapy and exercises, not surgical intervention, which could make the situation worse.

On August 26, 1992, the Claimant went to Dr. Sarshar, complaining of numbness and tingling of his finger on the left hand. Dr. Sarshar noted swelling and discoloration, and diminished sensitivity on the left. The Claimant had undergone a nerve conduction study, which showed early stage carpal tunnel syndrome. Although Dr. Halikman wished to proceed with surgery, Dr. Sarshar felt that the Claimant should be treated with splinting, vitamins, and injections of steroids. He left him on restrictions.

On January 14, 1993, Dr. Pidlaoan saw the Claimant, noting that he had some swelling in his left hand, but full mobility. He felt that the Claimant could return to modified work.

On February 15, 1993, the Claimant saw Dr. Sarshar, who noted that he had slow but progressive improvement, and still had limitations to his left hand. The Claimant saw Dr. Sarshar again on April 5, 1993, and he noted excellent improvement and a satisfactory recovery by the Claimant; he felt that the Claimant could perform his regular work.

The Claimant was next seen by Dr. Dollette on May 6, 1994, for treatment of an injury that he suffered on May 5, 1994 (CX 2). The Claimant reported that he had been pulling hoses and putting blanks in the tank, when his left elbow and hand started tingling, and his fingers turned purple. He denied any trauma to his left elbow or hand. The report notes the Claimant's previous carpal tunnel surgery on the left and right wrists, and previous injury of the left hand.

Physical examination showed some restricted motion due to pain on certain resisted motion of the left elbow. There was a positive Tinel sign on the medial epicondyle region. There was no gross swelling, and the left wrist was negative for Tinel Sign. The circulation in the left hand was quite excellent, and the grip was strong. Sensitivity of the tips of the fingers seemed to be decreased on the forefinger, middle finger, and ring finger, with slight numbness of the left little finger; the thumb was normal. There was diffuse aching on the proximal third of the left forearm. An x-ray of the left elbow showed no abnormality. Dr. Dollette's diagnosis was sprain of the left elbow with ulnar nerve neuritis.

The Claimant was given a "heelbo" to use at work, and samples of Naprosyn. He was instructed to do modified duty, with no lifting over ten pounds, and restricted to ground level work, with no climbing of ladders and limited use of his left hand.

Dr. Hector Feliciano saw the Claimant on a follow up visit on May 9, 1994 (CX 2). The Claimant reported less pain in his left elbow after resting for three days. He still had tingling on the ulnar aspect of his left hand, and fourth and fifth finger, but it was less. On physical examination of the Claimant, Dr. Feliciano noted that pushing on the medial aspect of the left elbow did not cause pain. He returned the Claimant to regular duty.

The Claimant saw Dr. Feliciano again on May 12, 1994, complaining of pain in his left elbow, up to the hand on the ulnar aspect, and the fourth and fifth fingers (CX 2). The Claimant had been able to perform his regular duties, including climbing ladders. On examination of the Claimant, Dr. Feliciano noted that his grip was "alright," and that he had good circulation of the forearm, and good movement of the elbow and wrist. He recommended nerve conduction studies, and advised the Claimant to take Motrin or Tylenol. He indicated that the Claimant could continue with his regular duties.

Dr. Albert Folgueras

Dr. Folgueras saw the Claimant on June 17, 1992 (EX 3). On examination, Dr. Folgueras noted swelling in the left hand, and pain in response to palpation, as well as tenderness in the dorsum ulnar side of the wrist. He had full range of motion of his wrist, and normal function of his left hand. X-rays showed an old fracture of the fifth metacarpal. Dr. Folgueras's impression was contusion of the left hand; he recommended warm soaks and exercises. He indicated that the Claimant could work with limited use of his left hand, but that the more he used his hand, the faster he would recover.

Dr. Folgueras saw the Claimant again on July 15, 1992. He was still having pain and swelling in his left hand, and had been assigned to light duty work. On examination, Dr. Folgueras noted swelling in the dorsum of the hand, and pain on palpation. There was no swelling of the wrist, and full flexion and extension of the wrist, with full pronation and supination of the forearm. He advised the Claimant to discard his arm sling, splint, and Ace bandage, and do hand exercises and use his hand.

Dr. Edward F. Wenzlaff

Dr. Wenzlaff examined the Claimant on June 17, 1992, at the request of the Employer (EX 3). He noted some thickening over the dorsum of the left metacarpals, but there was no swelling, and normal range of motion in the wrist. There was slight thickening about the fifth metacarpal, but the Claimant's wrist moved normally, and all joints seemed to move normally on a passive basis. There was no evidence of contracture. X-rays showed no fracture at the middle metacarpals, which were where the Claimant was struck with the valve.

Dr. Wenzlaff noted that the Claimant had been able to work until the past Monday, when he saw another physician who placed him out of work. Dr. Wenzlaff did not understand this, as he felt that the thickening about the dorsum should prevent the Claimant from working. He felt that he had recovered, and was able to perform his regular work.

Dr. Louis S. Halikman

The Claimant saw Dr. Halikman on June 29, 1992, complaining of swelling and tenderness. Dr. Halikman put him off work, and recommended physical therapy and a brace. Dr. Halikman saw the Claimant on July 13, 1992, noting severe swelling in his left wrist, and difficulty moving his fingers, with diminished sensation. He referred the Claimant for a bone scan, and kept him off work. The Claimant visited Dr. Halikman on July 27, 1992, who reported that the Claimant was not doing well, and still had significant swelling in his left hand. He felt that the Claimant could be developing a condition known as Secretain's disease, a condition where the process of swelling begins after an injury, and then progresses. Dr. Halikman kept the Claimant off work, and recommended daily therapy.

The Claimant underwent nerve conduction testing on July 24, 1992, which showed possible early carpal tunnel syndrome, as well as some denervation in the ulnar distribution in the left hand. Dr. Halikman saw the Claimant on August 10, 1992, noting that he still had a significant amount of dorsal swelling, and had developed atrophy of the intrinsic musculature of the left hand. The results of the electrodiagnostic study correlated with these findings. The Claimant remained off work, and was to continue physical therapy, with decompressive surgery a possibility. He saw the Claimant on August 24, 1992, again noting that he was having increasing problems with his left hand, and had developed atrophy. Dr. Halikman saw the Claimant on September 4, 1992, noting that he still had firm swelling of the dorsal aspect of the left hand; the Claimant remained on restrictions.

On September 12, 1992, Dr. Halikman performed surgery on the Claimant's left wrist, specifically, median and ulnar nerve decompressions. He advised that the Claimant not return to work Dr. Halikman saw the Claimant in follow up on September 15, 1992, noting that he reported a lot of pain in his left hand and fingers after his September 12 surgery.

On September 16, 1992, Dr. Halikman reported that the Claimant had a spasm or

embolization of the digital arteries to his right ring finger, the origin of which was uncertain. He advised the Claimant to quit smoking, stating that it (the spasm or embolization) was not an occupational disease, and he could not correlate it with any of the Claimant's previous problems. The Claimant saw Dr. Halikman on September 21, 1992 in followup (EX 3). Dr. Halikman reported that the Claimant was doing well with his left hand after median and ulnar nerve compressions. He did not think that the Claimant should be working yet.

At the Claimant's October 9, 1992 visit, Dr. Halikman noted that his left hand was doing very well, with excellent function and grip strength on the left, with no swelling. However, he had persistent numbness and tingling on the right, and Dr. Halikman felt he could not return to work. Following the Claimant's October 14, 1992 visit, Dr. Halikman released him to return to his regular work.

In a report dated November 16, 1992, Dr. Halikman stated that the Claimant's May 14, 1992 injury to his left hand had no relationship to the condition which necessitated surgery on his right upper extremity. At the Claimant's December 30, 1992 visit, Dr. Halikman referred him for physical therapy, following his surgery for ulnar nerve transposition at the right elbow. Dr. Halikman saw the Claimant on February 24, 1993, noting that he was doing well, but still had some discomfort; he recommended physical therapy. Again, on March 17, 1993, Dr. Halikman noted that the Claimant had outstanding results from surgery, and had full range of motion in his wrists and fingers. He needed no further treatment.

Dr. Halikman saw the Claimant on May 20, 1994, for an orthopedic examination. He indicated that he had treated the Claimant in 1992, when he underwent a medial and ulnar nerve decompression at his left wrist, with an excellent clinical result. Dr. Halikman subsequently operated on the Claimant's right wrist and elbow, after electrodiagnostic studies demonstrated right median nerve compression at the wrist, and ulnar nerve compression at the elbow. The Claimant had an excellent clinical result.

The Claimant reported to Dr. Halikman that he had constant pain in his left elbow, and numbness of the middle, ring, and little fingers of his left hand. He had no history of any injuries, but believed that pulling hoses and climbing may have caused the problem. On his examination of the Claimant, Dr. Halikman noted that the ulnar nerve was tender behind the medial humeral condyle of the left elbow. Tinel's sign was also positive at this level, and there was weakness in the interosseous muscles of the left hand. But there was no atrophy of the first dorsal interosseous or abductor digiti quenti muscles. He found hypesthesia in the classic ulnar distribution of the left hand, including the ulnar half of the ring finger and the entire little finger. Dr. Halikman reviewed an x-ray taken on May 6, 1994, which showed no abnormalities in the left elbow.

It was Dr. Halikman's impression that the Claimant had left ulnar neuropathy. He requested electrodiagnostic studies, and indicated that the Claimant could very well need surgery. According to Dr. Halikman:

> It is conceivable that heavy industrial use of the left upper extremity could cause this problem. However, this is not a common presentation. There is no description of any injury; the patient appears to have been doing his usual job. This patient's current problem does not relate in any way to the surgery which I had done previously to his left hand.

Dr. Halikman saw the Claimant again on May 27, 1994, after receiving the results of the electrodiagnostic studies. He indicated that the Claimant had moderate left ulnar neuropathy at the elbow. Dr. Halikman felt that the Claimant would need an anterior submuscular transposition of the left ulnar nerve at the elbow, the same operation that had been performed on his right elbow. Dr. Halikman stated that, in his opinion, under certain circumstances the Claimant's condition could be work related.

The Claimant underwent surgery on June 4, 1994. Dr. Halikman performed an anterior transposition of the left ulnar nerve at the elbow. At an emergency visit on June 7, 1994, Dr. Halikman noted that the Claimant had developed significant numbness of his ring and little fingers on his left hand, worse than before his surgery. Dr. Halikman noted some swelling, which he felt was of little clinical concern. However, the Claimant had significant weakness of the ulnar nerve in both the motor and sensory components. The Claimant underwent surgery the following day, and Dr. Halikman found a post-operative hematoma, and marked swelling of the ulnar nerve. He extended the decompression, and performed an external neurolysis. When the Claimant was seen in the recovery room after surgery, he had recovered feeling in his fingers, and his pain was gone.

Dr. Halikman saw the Claimant on June 23, 1994 on followup. The Claimant still had hypesthesia in the ulnar distribution of the left elbow, and significant stiffness in his left elbow. But the ulnar nerve was not tender in its anterior transposed position, which was an excellent clinical sign. Dr. Halikman referred the Claimant to therapy for his elbow stiffness, and indicated that he was not able to work.

The Claimant visited Dr. Halikman on July 14, 1994. He still had significant problems with his left arm, with symptoms and signs of ulnar neuropathy. Dr. Halikman indicated that he had fairly extensive hypesthesia in his ring and little fingers on the left hand, and some weakness of the interosseous muscles, as well as early atrophy of the first dorsal interosseous muscle. He felt that the Claimant needed physical therapy to regain function in his left hand; he referred him to the Medical Center, and indicated that he was not able to work.

Dr. Halikman saw the Claimant on August 4, 1994, and indicated that his left elbow had markedly improved. The pain was gone, and the Claimant had regained full range of motion. He was also starting to regain sensitivity in his ring and little fingers on his left hand. On his physical examination of the Claimant, Dr. Halikman found hypesthesia in the ulnar distribution of the left hand. But the scar over his left elbow was not tender, and he had regained full range of motion. There was no atrophy of the first dorsal interosseous muscle, and interosseous strengths were excellent. Dr. Halikman released the Claimant to return to work at his regular duties on Monday, August 8, 1994.

Dr. Halikman saw the Claimant on September 27, 1994, noting that his left elbow pain and left hand pain were gone. But he still had numbness in the classic ulnar distribution in the ring and little fingers. The Claimant's strength was excellent, and there was no sign of any atrophy of the first dorsal interosseous or abduct digiti quenti muscles. Dr. Halikman anticipated that the Claimant's symptoms would resolve fully, but that it could take a year or more for all of the numbness to disappear.

The Claimant visited Dr. Halikman on December 13, 1994, complaining of symptoms in his left hand. Dr. Halikman indicated that the Claimant still had relatively little ulnar nerve function, and persistent numbness and some weakness in his left hand. On his physical examination of the Claimant, Dr. Halikman found hypesthesia, but not analgesia, in the ring and little fingers. There was slight atrophy of the first dorsal interosseous muscle, but the ulnar innervated motor strengths were satisfactory. Dr. Halikman found no discrete tenderness over the ulnar nerve in its anterior transposed position. Dr. Halikman was concerned about the Claimant's prognosis, and recommended that electrodiagnostic studies be done again.

Dr. Halikman saw the Claimant on January 3, 1995, and indicated that his left arm was not doing well. The electrodiagnostic studies showed worsening of the ulnar nerve function at the elbow. On physical examination of the Claimant, Dr. Halikman noted that bringing the Claimant's elbow to full extension aggravated his pain. The Tinel's sign was positive over the ulnar nerve in its anterior transposed position, and there was hypesthesia in the classic ulnar distribution of the left hand. There was also weakness of the interosseous muscles, and possibly some atrophy of the first dorsal interosseous muscle. These findings were classic for persistent ulnar neuropathy.

Dr. Halikman indicated that the Claimant had been working, but with increasing difficulty. The Claimant asked that Dr. Halikman try again to repair his elbow, and he agreed. On February 21, 1995, Dr. Halikman performed an ulnar nerve decompression and internal neurolysis. He noted that the nerve was tightly bound by scar.

Dr. Halikman saw the Claimant again on March 2, 1995, noting that he was quite stiff. He was able to extend the fingers of his left hand, but had significant hypesthesia in the ulnar distribution. Dr. Halikman felt that it could be some time before any improvement was seen. He referred the Claimant for physical therapy, which he expected to be brief. He also anticipated that the Claimant would be able to return to work after his next visit.

The Claimant visited Dr. Halikman on May 4, 1995. He was not doing well, and had symptoms indicative of ulnar palsy at the left elbow, as well as dense hypesthesia in the ulnar distribution, and fairly significant ulnar motor palsy in his left hand. He held his hand in a claw position. Dr. Halikman requested that he be fitted with an ulnar splint.

Dr. Halikman wrote to the Employer on June 1, 1995, indicating that the Claimant was not making any progress since his surgery, and had been fitted with a brace. According to Dr. Halikman, it was reasonable to expect that it would take at least a year from surgery for maximum

benefit to be achieved. He indicated that the Claimant could not work his regular duties, but could do restricted work, with no work with his left hand. At the Claimant's June 9, 1995 visit, Dr. Halikman fitted him with splints, and indicated that both he and Dr. Narrow thought that he could benefit from a tendon transfer.

On July 10, 1995, Dr. Halikman wrote to the Claimant's attorney, indicating that pulling hoses and climbing may have caused his problems with ulnar nerve compression at the left elbow. He stated that these type of activities can cause cubital tunnel syndrome if performed frequently enough, and depending on the Claimant's actual job duties, could be the source of his problem. Dr. Halikman stated:

> When I had initially examined this patient on 6-15-92, it appeared that his pathology was confined to his left wrist. It is my understanding that an injury to his left wrist occurred at work in May 1992. If that, indeed, is correct, then that injury did not produce his discomfort. A direct blow to the elbow can produce ulnar neuropathy and it can also be caused by appropriate activity as noted above.

Dr. Halikman saw the Claimant on August 21, 1995, for an extended follow up visit. He stated that, six months after the Claimant's surgery, he had made no progress. On examination, Dr. Halikman noted that the nerve appeared to be compressed at the distal portion of the medial humeral condyle; there was dense hypesthesia in the ulnar distribution, with no ulnar intrinsic function. Dr. Halikman recommended a repeat electrodiagnostic study of the left ulnar nerve only.

Dr. Halikman saw the Claimant on July 11, 1995, indicating that he had made no improvement, and that further surgery of the ulnar nerve was not likely to be helpful, although a tendon transfer could be done to prevent flexion deformity. He indicated that the Claimant would benefit from any form of light duty work, to take his mind off his pain.

At his July 27, 1995 visit, the Claimant complained of constant pain down his forearm on the ulnar side. Dr. Halikman noted dense ulnar hypesthesia and motor palsy. He did not think it was likely that further surgery would help; he reassured the Claimant that nothing seemed to be wrong, and the pain was only neurologic.

Dr. Halikman saw the Claimant on December 27, 1995, noting that he had performed a repeated decompression of the ulnar nerve at the cubital tunnel about ten days earlier. He noted that there were large areas of swelling and scarring of the nerve, and indicated that the flexion deformity at the ring and little fingers was due to neuromuscular irritability. He did not think that a tendon transfer would work, and could possibly make the Claimant worse. He did think that the nerve would eventually recover. Dr. Halikman indicated that the Claimant was unable to work.

At his January 2, 1996 visit, the Claimant was fitted with braces, and Dr. Halikman gave him samples of Ultram for his pain (EX 3). Dr. Halikman received a report from Dr. Charles M.

Narrow, to whom he had referred the Claimant, dated January 18, 1996 (EX 3). After examining the Claimant's left hand, Dr. Narrow assessed him with probable early reflex sympathetic dystrophy, with continued myoligamentous pain. Dr. Narrow wanted to do stellate ganglion blocks, as well as a bone scan to evaluate the stage of RSD, if that was what the Claimant had.

The Claimant returned to Dr. Halikman on January 29, 1996. Dr. Halikman discussed with the Claimant the fact that he was not making any progress, and that Dr. Halikman had probably reached the limits of what he could do for him. He noted that the Claimant still complained of pain in his elbow, and ring and little fingers. There was also dense hypesthesia. He noted that the ring and little fingers tended to flex, a rather unusual situation, but the splints corrected this. Dr. Halikman indicated that a cervical epidural block was an alternative. According to Dr. Halikman, the Claimant's problem was clearly ulnar nerve in origin. Even though his nerve was freed in the most recent decompressive procedure, function had not returned. Dr. Halikman referred the Claimant to Dr. Lee Dellon, an expert on nerve pathology and repair.

Dr. Halikman saw the Claimant again on February 12, 1996. The Claimant had been to see Dr. Dellon, who agreed that there was no function in the ulnar nerve, and that it might not be salvageable. Dr. Halikman noted that the Claimant had no sensation at all, not even protective sensation, in his ulnar distribution, strong evidence that recovery was not likely. Dr. Halikman and Dr. Dellon discussed possible surgeries; in the meantime, Dr. Halikman prescribed Baclofen to reduce spasm.

The Claimant saw Dr. Halikman on February 19, 1996. The Baclofen had not provided any relief. Dr. Halikman indicated that he might consider the use of a TENS unit, as well as muscle block. He indicated that the Claimant remained unable to work.

Dr. Halikman saw the Claimant on February 26, 1996, and advised him to resume treatment with Dr. Dellon, as he did not have any experience at that level of nerve treatment. He felt that the Claimant had exhausted his experience level, but that there were several specialized techniques that Dr. Dellon could be able to do for him.

Dr. Halikman testified by deposition on April 26, 1994 (EX 4). At that time, he had not seen the Claimant since March 17, 1993, when he found that the Claimant had recovered very well from surgery on both extremities. At that time, there were no findings, and Dr. Halikman discharged the Claimant to return to work at full duty. He testified that the Claimant's left wrist and hand problems were most likely related to his work accident, but that the problems in his right upper extremity were not. Specifically, he stated that the Claimant's symptoms of ulnar nerve compression at the right elbow, and median nerve compression at the right wrist did not relate in any way to an injury involving his left extremity. He noted that there was no medical literature that indicated that if one extremity is injured, any kind of use of the opposite extremity would produce problems.

According to Dr. Halikman, there are a large number of conditions known to produce median nerve compression at the wrist, and ulnar nerve compression at the elbow, including excessive alcohol intake and cigarette smoking. Nor did he think that there was any connection between the Claimant's right extremity problems and the use of his hand at work.

Dr. Halikman disagreed with Dr. McClinton that the Claimant had a right ulnar artery thrombosis, noting that the nuclear blood flow test, which Dr. McClinton did not consider, was negative. He also testified that, when a person's work involves repeated forced flexion of the wrist, as in an assembly line, or work involving fine control, carpal tunnel syndrome can be occupationally related. But there was no medical evidence that heavy lifting causes carpal tunnel syndrome. He noted that the use of common hand tools brings the wrist into the extended position, and indeed tools could not be used by the hand in a flexed position.

Dr. Halikman noted that he biopsied the Claimant's right wrist, and found no discernable cause for his synovitis. Nor did he find any cause for the Claimant's slight synovitis of the left wrist. He also testified that pipe fitting was not the type of occupation that normally would result in the development of carpal tunnel syndrome.

Dr. Charles M. Narrow

Dr. Narrow saw the Claimant on March 30, 1995, for evaluation and possible treatment for pain management (EX 3). He noted a positive Tinel's sign at the cubital tunnel, as well as over the Guyon's canal on the left. The Claimant had full range of motion in flexion and extension, with no crepitus in the elbow joint; pronation and supination were not painful. There was no motor weakness in the left hand, and no atrophy. Dr. Narrow's assessment was possible sympathetic maintained pain in the left hand, and probable continued pain from longstanding compression of the ulnar nerve at Guyon's canal. He gave the Claimant an injection into the Guyon's canal on March 30, 1995, to decrease nerve swelling.

Dr. Narrow saw the Claimant again on April 13, 1995; the Claimant reported that he was only having modest pain from the use of Tegretol. Dr. Narrow noted a significantly positive Tinel's at the transposed ulnar nerve, and diagnosed post cubital tunnel release with continued sympathetic maintained pain. He gave him a stellate ganglion block.

At his April 27, 1995 visit, the Claimant indicated that he had received no real benefit from the block. On examination, Dr. Narrow found no true area of exquisite tenderness, and he diagnosed neuritic pain, left ulnar innervated hand, probably secondary to long standing compression. He prescribed neuritic pain medicine.

Dr. Narrow saw the Claimant on May 18, 1995, after going to hand therapy, which made no difference. Dr. Narrow diagnosed continued left ulnar hand neuritic pain and clawing, and felt that the Claimant would benefit from a tendon transfer.

On June 1, 1995, Dr. Narrow wrote to Dr. Halikman, agreeing with his plan to perform a left release. He noted that the Claimant continued to have mild clawing of the left ulnar digits.

Dr. Narrow saw the Claimant on January 18, 1996, noting that he had significant contractures of the left middle and ring finger, which could be extended with active pressure, with significant pain. He diagnosed probable early reflex sympathetic dystrophy with continued myoligamentous pain.

Dr. A. Lee Dellon

Dr. Dellon saw the Claimant on February 2, 1996, on referral by Dr. Halikman (CX 4). He discussed the Claimant's history of treatment, noting that currently he had permanent numbness in his fingers, cramping in his hand, and pain at his elbow. Dr. Dellon stated that the Claimant held his hand with the wrist somewhat flexed, and the little and ring fingers curled into his hand, with his elbow at his side. On examination of the Claimant's hand, Dr. Dellon noted severe spasticity in the little and ring fingers, which he could only extend if he flexed the Claimant's wrist.

Dr. Dellon stated that the Claimant had some numbness below the incision, but no evidence of a neuroma of the medial antebrachial or medial brachial cutaneous nerve. There was no evidence to suggest regeneration of the ulnar nerve. Sensory testing showed no perception of one-point static, or one-point moving, and there was no two-point discrimination in his little finger. The index finger had good measurements bilaterally. The computerized grip testing showed a loss of approximately 75% of grip strength on the left. The results indicated that the Claimant gave his maximal effort, with no evidence of malingering.

Dr. Dellon concluded that the Claimant's ulnar nerve had very little, if any, function. He indicated that, most likely, there was a loss of circulation to the intrinsic or longitudinal blood supply to the nerve during the previous surgeries. He suggested several methods of treatment, including injections, or lengthening of the profundus tendons, as well as a transfer of the nerve in the middle finger to the little finger. He also felt that a TENS unit could be useful.

The Claimant met with Dr. Dellon on March 14, 1996 to discuss surgery to lengthen the profundus tendons, and possible denervation or additional release of the ulnar nerve, which was Dr. Dellon's first recommendation. They also discussed a subsequent transfer of nerves from the middle finger to the little finger.

Dr. Dellon performed surgery on March 20, 1996: a submuscular transposition of the ulnar nerve at the elbow, extensive neurolysis of the ulnar nerve at the elbow, and neurolysis of the median nerve and the proximal forearm. His postoperative diagnosis was severe recurrent left ulnar nerve compression at the elbow, and entrapment of the median nerve of the forearm.

The Claimant saw Dr. Dellon on April 25, 1996. The severe pain in his elbow was not

completely gone, but it was better. The Claimant's little and ring fingers still curled inward, but were able to be extended with much less force, and were not quite as spastic. Dr. Dellon referred the Claimant for the construction of a dynamic wrist splint, to be worn as much as possible during the day. The Claimant still had no sensation in his little finger.

Dr. Dellon saw the Claimant on May 23, 1996. His hand still did not show any evidence of recovery of sensation from the ulnar nerve. His little and ring fingers moved easier on extension, but still went into a claw deformity. Dr. Dellon indicated that it was appropriate to begin reconstruction of the Claimant's hand, and indicated that he was seeking approval from the Employer for surgery.

Dr. Dellon performed surgery on July 1, 1996 to correct clawing and inability to pinch by three tendon transfers and tenotomy of the left little finger sublimis muscle. His postoperative diagnosis was severe and permanent left ulnar nerve paralysis. At the Claimant's visit on July 11, 1996, Dr. Dellon was very pleased with the early healing of the Claimant's hand after the tendon transfers. He noted that the clawing had been corrected, as well as the pulling in of the little and ring fingers at the PIP joint. The thumb and index finger were in good position for pinch. Dr. Dellon put the Claimant in a fiberglass splint.

The Claimant visited Dr. Dellon on August 22, 1996, and he was extremely pleased with the Claimant's hand function. He had learned to control pinch, and the clawing was corrected. Dr. Dellon wanted to proceed with restoration of the sensation to the little finger, and he sought approval for this surgery from the Employer. On September 16, 1996, Dr. Dellon performed a tendon transfer and neurotization of the little finger, with a vascularized nerve graft from the middle to the little finger. His postoperative diagnosis was ulnar nerve paralysis, and abduction deformity and loss of sensitivity of the little finger.

By February 1997, the Claimant was not progressing, and Dr. Dellon sought permission to perform further surgery. Dr. Dellon performed a micro-neurolysis and dissection of the ulnar digital nerves to the little finger and the transferred ulnar digital nerves to the middle finger, a resection of a neuroma, and a repair of the ulnar digital nerve to the middle finger and the ulnar digital nerve to the little finger, on March 3, 1997 (EX 3).

The Claimant saw Dr. Dellon on June 24, 1997. The nerve appeared to have grown approximately one centimeter. However, the Claimant still had significant pain, which caused him to be unsuccessful in therapy, and Dr. Dellon indicated that no further therapy would be attempted. Dr. Dellon prescribed medication for pain. He stated that the Claimant would not be able to return to work. Dr. Dellon saw the Claimant on September 30, 1997, and indicated that there was definite progress in restoring function to the left little finger, and the Claimant could feel moving and constant touch. Dr. Dellon started the Claimant on an intensive program of sensory re-education. The Claimant was still unable to get his middle, ring, and little fingers out of his palm, and thus unable to hold large things. Dr. Dellon planned a fusion of the PIP joints.

On October 29, 1997, Dr. Dellon performed a fusion of the left little, ring, and middle finger proximal interphalangeal joints. His postoperative diagnosis was flexure contractures of the left little, ring, and middle finger, proximal interphalangeal joint.

On December 8, 1997, Dr. Dellon indicated that sensory testing showed very good regeneration to the tip of the little finger, and no further surgery to the nerves in the hand was planned. The Claimant would proceed with the fusions of the PIP joints. On December 16, 1997, Dr. Dellon saw the Claimant, and reviewed x-rays, which showed that fusions were occurring. The Claimant still had pain over one aspect of the middle finger. Dr. Dellon performed surgery to remove a pin in the Claimant's left middle finger on March 9, 1998.

The Claimant saw Dr. Dellon on June 2, 1998. He was continuing to progress with his hand, but was having pain in his ring finger. Dr. Dellon sought approval from the Employer for surgery to remove the wire, which he did on June 10, 1998.

On August 10, 1998, Dr. Dellon wrote to the Employer, indicating that the Claimant was not able to return to work, due to the complete disability of his left upper extremity. On August 25, 1998, he wrote to the Claimant's attorney, indicating that the Claimant had reached maximum medical improvement, and had no industrial use of his left hand. On September 28, 1998, Dr. Dellon removed wires from the Claimant's little and middle fingers.

Dr. Dellon saw the Claimant on January 5, 1999, for an evaluation of his impairment and a disability rating. Dr. Dellon indicated that the Claimant continued to have pain in his hand. He discussed the Claimant's treatment history, including his multiple surgeries. According to Dr. Dellon, the Claimant has a complete ulnar nerve paralysis, and using the *AMA Guides to Impairment, 4th Edition*, he has a 7% impairment of the upper extremity related to sensory function and a 35% impairment related to motor function, for a combined motor and sensory deficit of 40% permanent partial impairment to the left upper extremity. Additionally, Dr. Dellon noted that the Claimant has loss of range of motion of his little, ring, and middle fingers, resulting in a 50% impairment of the little finger, ring finger, and middle finger. Using the charts, Dr. Dellon calculated an 18% impairment of the upper extremity. Combining the impairment for loss of range of motion and ankylosis, and the impairment for the ulnar nerve problem, Dr. Dellon arrived at a 51% impairment of the entire left upper extremity.

Finally, factoring in residual symptoms related to cold and tolerance and pain at the elbow, and pain in the hand, Dr. Dellon calculated a 60% permanent partial impairment of the entire left upper extremity. He stated that essentially the only useful fingers the Claimant has are his thumb and index finger.

The Claimant visited Dr. Dellon on September 26, 2000, with some drifting of his fingers. Dr. Dellon performed sensory testing, which showed some improvement. Dr. Dellon indicated that no further treatment was recommended, and that the Claimant would remain disabled and unable to work.

Dr. Dellon reported on the results of the Claimant's quantitative sensory testing on October 18, 2000 (EX 3). This testing showed that his index finger bilaterally had normal pressure perception for moving and static touch. The left little finger had improvement in moving and static touch. Additionally, his pinch and grip strength had improved. Dr. Dellon indicated that no further treatment was recommended.

Dr. Joel Meshulam

Dr. Meshulam evaluated the Claimant at the request of the Employer, and prepared a report dated August 15, 2001 (EX 3). Dr. Meshulam also reviewed the Claimant's medical records. He discussed the Claimant's history of injury and treatment, and his current condition. He also noted that the Claimant had a previous cervical injury in 1990, and underwent a C4/C5 discectomy and fusion; he also had a left hand fracture in 1987. At the time, the Claimant was taking only Advil for pain.

On physical examination of the Claimant, Dr. Meshulam noted significant deformity and muscle loss in the Claimant's left forearm, consistent with his prior surgeries. The Claimant had a claw deformity of the third, fourth, and fifth fingers of the left hand. He had diminished pinch strength in his left hand, with evidence of thenar and hypothenar atrophy. The Claimant had full range of motion and good strength against resistance in his right upper extremity, with no sensory deficits noted. The extremities were without edema.

Dr. Meshulam noted that the Claimant had a history of coronary artery disease, and abnormalities on his EKG. Dr. Meshulam felt that he has a 25% whole person impairment due to his coronary artery disease, which was present before his May 1992 injury. He also has a 24% impairment of his whole person due to the cervical pathology relative to his 1990 fusion. Additionally, the Claimant has respiratory impairment, resulting in a 15% whole person impairment, of which Dr. Meshulam believed that 10% preceded the Claimant's injuries in 1992.

Dr. Meshulam stated that there was no impairment of the Claimant's right upper extremity, and he had no pain, weakness, or other complaint. Taking into account weakness, diminished use of the hand, and persistent ulnar abnormalities, Dr. Meshulam felt that the Claimant had a 45% impairment of his left upper extremity related to his May 1992 injuries.

Dr. Steven L. Friedman

Dr. Friedman examined the Claimant on July 17, 2001, for purposes of a medical evaluation (EX 3). He discussed the Claimant's injury and history of treatment, as well as his 1985 right hand injury and his discectomy, and history of cardiac disease. The Claimant told Dr. Friedman that he had constant pain in his left hand, arm, and upper extremity. He was taking no pain medication other than occasional Advil. The Claimant had constant numbness in the little and ring fingers of his left hand, although he had recovered some degree of sensation with pressure over the ulnar tip of his little finger.

On examination of the Claimant, Dr. Friedman noted full, pain free range of motion in the right shoulder, elbow, wrist, and digits of the right hand. There was no deformity in the right upper extremity, and the skin was intact. There was no focal sensory or motor deficit in the right upper extremity. The Claimant had full, pain free range of motion in his cervical spine, with no localized tenderness or spasm. The Claimant's left upper extremity had full shoulder range of motion; elbow range of motion was from 10 degrees to 130 degrees of flexion. The Claimant had full supination and pronation.

Dr. Friedman's examination of the Claimant's left wrist showed 70 degrees of flexion, and 45 degrees of extension. The index finger had full range of motion in the MP, PIP, and DIP joints, and the thumb had full range of motion at the IP, MP, and CMC joints. However, he had marked restriction of motion in the MP joints of the middle, ring, and little fingers. He also had arthrodesis of the middle, ring, and little finger PIP joints. There was no active range of motion in the DIP joints of the middle, ring, and little fingers, which were essentially ankylosed at 45 degrees of flexion. The Claimant was insensate over the ulnar aspect of his middle finger and radial and ulnar aspect of the ring finger, and radial aspect of the little finger. There was considerable atrophy in the intrinsic muscles in the left hand.

Dr. Friedman estimated the Claimant to have an 8% whole person disability due to his cervical fusion, and no impairment of his right upper extremity due to his previous median and ulnar nerve decompression at the wrist, and ulnar nerve decompression at the elbow. With respect to the Claimant's left upper extremity, Dr. Friedman felt that he had reached maximum medical improvement. He estimated that the Claimant's middle, ring, and little fingers each had an 87% impairment. In the middle finger, this equaled a 17% hand impairment, and in the little and ring fingers, a 9% contribution to hand impairment from each finger. These values total a 35% impairment of the hand. Dr. Friedman also took into account impairment related to the Claimant's ulnar nerve, motor, and sensory deficits, and concluded that the Claimant had a 50% permanent and partial impairment of the left upper extremity attributable to the ulnar nerve deficit. Using the AMA guides, and combining this with the 35% left upper extremity impairment, Dr. Friedman arrived at a 68% permanent and partial impairment of the left upper extremity. Taking into account the Claimant's complaints of pain, he estimated that he had a 73% permanent and partial impairment of his left upper extremity due to his May 1992 injury.

II. Stipulations

The parties have stipulated, and based on the record I find the following:

I. 33 U.S.C. § 901 et seq (hereinafter the Act) is applicable to this claim.

II. The Claimant and Employer were in an employer/employee relationship at the time of the accident or injury.

III. The date of the accident or injury was May 14, 1992, and May 20, 1994.

IV. The Employer was provided with timely notice of the injury.

V. The Claimant's filing of the notice of claim was timely.

VI. The Employer filed its notices of controversion on June 28, 2001, September 24, 1993, August 19, 1993, December 2, 1992, and March 6, 1995.

VII. The Employer paid the Claimant temporary total disability benefits from September 17, 1992 to January 14, 1992, at the rate of $359.12 a week, for a total of $1,436.48.

VIII. The Employer paid the Claimant temporary total disability benefits from February 25, 1995 to April 10, 2002. and continuing, at the rate of $359.12 a week, for a total of $133,490.03.

IX. The Claimant's average weekly wage was $538.68.

X. The Employer has paid for medical services under Section 7 of the Act.

III. Issues

The issues before me are these:

I. Whether the condition of the Claimant's left hand and arm is causally related to a work injury that occurred on May 14, 1992, or May 20, 1994.

II. The date of maximum medical improvement.

III. The nature and extent of permanent impairment to the Claimant's left hand or arm.

IV. Whether the Employer/Insurer is entitled to Section 8(f) relief.

IV. Discussion

A. Injury and Causation

It is well-established that an administrative law judge is entitled to evaluate the credibility of all witnesses and to draw her own inferences from the evidence. *Wendler v. American National Red Cross*, 23 BRBS 408, 412 (1990). It is also well-established that the administrative law judge is not bound to accept the opinion or theory of any particular medical examiner. *Hite v. Dresser Guiberson Pumping*, 22 BRBS 87, 91 (1989).

The Act provides a presumption that a claim comes within its provisions. *See*, 33 U.S.C.

§ 920(a). This presumption "applies as much to the nexus between an employee's malady and his employment activities as it does to any other aspect of a claim." *Swinton v. J. Frank Kelly, Inc.*, 554
F.2d 1075 (D.C. Cir. 1976), *cert. denied*, 429 U.S. 820 (1976). The Claimant's uncontradicted credible testimony alone may constitute sufficient proof of physical injury. *Golden v. Eller & Co.*, 8 BRBS 846 (1978), *aff'd*, 620 F.2d 71 (5th Cir. 1980); *Hampton v. Bethlehem Steel Corp.*, 24 BRBS 141 (1990); *Anderson v. Todd Shipyards, supra*, at 21; *Miranda v. Excavation Construction, Inc.*, 13 BRBS 882 (1981).

However, this statutory presumption does not dispense with the requirement that a claim of injury must be made in the first instance, nor is it a substitute for the testimony necessary to establish a "prima facie" case. The Supreme Court has held that "[a] prima facie 'claim for compensation,' to which the statutory presumption refers, must at least allege an injury that arose in the course of employment as well as out of employment." *United States Indus./Fed Sheet Metal, Inc., v. Director, Office of Workers' Compensation Programs, U.S. Dept. Of Labor*, 455 U.S. 608, 615 (1982).

To establish a prima facie claim for compensation, a claimant need not affirmatively establish a connection between work and harm. Rather, a claimant has the burden of establishing only that (1) the claimant sustained physical harm or pain and (2) an accident occurred in the course of employment, or conditions existed at work, which could have caused the harm or pain. Once this prima facie case is established, a presumption is created under Section 20(a) that the employee's injury or death arose out of employment. To rebut the presumption, the party opposing entitlement must present substantial evidence proving the absence of or severing the connection between such harm and employment or working conditions. *Parsons Corp. of California v. Director, OWCP*, 619 F.2d 38 (9th Cir. 1980); *Butler v. District Parking Management Co.*, 363 F.2d 682 (D.C. Cir. 1966); *Ranks v. Bath Iron Works Corp.*, 22 BRBS 301, 305 (1989). Once the claimant establishes a physical harm and working conditions which could have caused or aggravated the harm or pain the burden shifts to the employer to establish that the claimant's condition was not caused or aggravated by his employment.

The Claimant argues that he is permanently and totally disabled as a result of his left ulnar nerve condition that first manifested itself on May 4, 1994. *See* Claimant's Posthearing Brief at 7. The Employer has not taken a position on the question of whether the Claimant's disability is a result of the 1992 injury, the 1994 injury, or a combination of both. Dr. Halikman, who treated the Claimant for both injuries (as well as problems with his left arm), released him to return to his regular work in October 1992, noting that his left hand was doing very well, with excellent function and grip strength. Indeed, Dr. Halikman apparently did not provide further treatment to the Claimant's left upper extremity until May 1994. At that time, Dr. Halikman indicated that the Claimant had an excellent clinical result from his 1992 left wrist nerve compression. At his deposition in April 1994, Dr. Halikman testified that the Claimant had recovered very well from the surgery to his left and right arms.

The Claimant also saw several physicians at the Eastern Industrial Medical Center. In April 1993, the last visit before his May 1994 injury, Dr. Sarshar noted that the Claimant had excellent improvement and a satisfactory recovery with his left hand, and could perform his regular work. There is no evidence, medical or otherwise, that the Claimant had continuing problems with his left hand, up until the incident of May 1994.

I had the opportunity to observe the Claimant at the hearing, and I found him to be a credible witness. His description of his problems with his left arm and hand, which began on May 5, 1994, after he had been pulling hoses and putting blanks in the tank of a ship, is consistent with the medical evidence of record, which documents chronic and progressive difficulties with the Claimant's left arm and hand after that date, resulting in multiple surgeries and permanent disability. Dr. Halikman, one of the Claimant's treating physicians, has stated that the Claimant's problems are related to his ulnar nerve, and that his work activities could have caused ulnar neuropathy of the type that he suffers.[1] No other physician has offered an opinion on this issue.

I find that the Claimant has established that he sustained physical harm or pain as a result of his work activities on May 5, 1994, and thus he is entitled to the presumption that his injury arose out of his employment with the Employer. The Employer has offered no evidence that the Claimant's condition was not caused or aggravated by his employment, and thus has not rebutted the Section 20 presumption of causation.

B. *Nature and Extent of Disability*

The burden of proving the nature and extent of disability rests with Claimant. *Trask v. Lockheed Shipbuilding Construction Co.*, 17 BRBS 56, 59 (1980). Disability is generally addressed in terms of its nature (permanent or temporary) and its extent (total or partial). The permanency of any disability is a medical rather than an economic concept. Disability is defined under the Act as an "incapacity because of injury to earn the wages which the employee was receiving at the time of injury in the same or any other employment." 33 U.S.C. § 902(10). Therefore, for the Claimant to receive a disability award, an economic loss coupled with a physical and/or psychological impairment must be shown. *Sproull v. Stevedoring Servs. of America*, 25 BRBS 100, 110 (1991). Thus, disability requires a causal connection between a worker's physical injury and his inability to obtain work. Under this standard, a claimant may be found to have either suffered no loss, a total loss or a partial loss of wage earning capacity.

As a general rule, if an injury occurs to a body part specified in the statutory schedule, then the injured employee is limited to the permanent partial disability schedule of payment contained in Section 908(c)(1) through (20). Thus, the Claimant is entitled to a statutorily defined period of permanent partial disability known as a scheduled award. Sections 8(c)(1)-(20) establish minimum levels of compensation to which an injured employee is automatically entitled

[1] Indeed, Dr. Halikman specifically noted that the Claimant's 1994 problem did not relate in any way to the surgery previously performed on his left hand.

as a result of his injury irrespective of his ability to prove an actual loss of wage-earning capacity. *See Travelers Ins. Co. v. Cardillo*, 225 F.2d 137 (2d Cir. 1954), *cert. denied*, 350 U.S. 913 (1955); *Greto v. Blakeslee, Arpaia & Chapman*, 10 BRBS 1000 (1979). Thus, scheduled benefits are exclusive in cases where the scheduled injury, which is limited in effect to the injured part of the body, results in a permanent partial disability.

Here, the Claimant's injury is limited in effect to his left upper extremity, and it has resulted in a permanent partial disability. Indeed, Dr. Halikman, Dr. Friedman, and Dr. Meshulam each have attached a specific percentage to the loss of use of the Claimant's left upper extremity.[2] Taking all of these factors into consideration, I find that the Claimant is only partially disabled, and thus he is limited to a scheduled award.[3]

In determining the extent of the Claimant's permanent partial disability, I have accorded greatest weight to the opinions of his treating physician, Dr. Dellon. Dr. Dellon saw the Claimant frequently between February 1996 and October 2000, and had the opportunity to observe his symptoms and capabilities over an extended period of time. In contrast, Dr. Friedman and Dr. Meshulam reviewed the Claimant's medical records, but they only saw the Claimant once. I find that Dr. Dellon's longitudinal observations of the Claimant and his condition allowed for a more accurate assessment of the Claimant's capabilities. Dr. Dellon took into account the Claimant's motor and sensory defects, his loss of range of motion in his fingers, and his symptoms relating to cold, tolerance, and pain. Thus, I credit his disability calculations over those of Dr. Meshulam and Dr. Friedman, and find that the Claimant has a 60 % permanent partial disability to his left upper extremity.

C. Date of Maximum Medical Improvement

An injured worker's impairment may be found to have changed from temporary to permanent if, and when, the employee's condition reaches the point of maximum medical improvement. *James v. Pate Stevedoring Co.*, 22 BRBS 271, 274 (1989); *Phillips v. Marine Concrete Structures*, 21 BRBS 233, 235 (1988); *Trask v. Lockheed Shipbuilding & Constr. Co.*, 17 BRBS 56, 60 (1985). Thus, an irreversible condition is permanent *per se. Drake v. General*

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[2] Although the Employer submitted evidence related to the existence of suitable alternative employment, the Claimant is entitled to the statutorily specified compensation for a scheduled injury, regardless of wage earning capacity.

[3] There is absolutely no objective medical evidence to establish that the Claimant has suffered a disabling injury of any kind to any part of his body other than his upper left extremity. While the medical opinions clearly establish that, due to his injury of May 1994, the Claimant can no longer perform the work duties required in his job as a longshoreman, there is no evidence that this injury was totally disabling in terms of the Claimant's ability to work in some suitable alternative employment. In fact, the three physicians who evaluated the extent of the Claimant's disability attached a specific percentage to the loss of use of the left arm.

Dynamics Corp., Elec. Boat Div., 11 BRBS 288, 290 n.2 (1979). A disability is also considered permanent if the employee's
impairment has continued for a lengthy period and appears to be of a lasting or indefinite duration, as distinguished from one in which recovery merely awaits a normal healing period. *Watson v. Gulf Stevedore Corp*., 400 F.2d 649, 654 (5th Cir. 1968), *cert. denied*, 394 U.S. 976 (1969). *See also Crum v. General Adjustment Bureau*, 738 F.2d 474, 480 (D.C. Cir. 1984) (physician's evaluations of claimant indicated that his heart condition, although improved, was of indefinite duration); *Air America, Inc. v. Director, OWCP*, 597 F.2d 773, 781-82 (1st Cir. 1979); *Care v. Washington Metro. Area Transit Auth.*, 21 BRBS 248, 251 (1988). In such cases, the date of permanency is the date that the employee ceases receiving treatment, with a view toward improving his condition. *Leech v. Service Eng'g Co.*, 15 BRBS 18, 21 (1982).

It is the medical evidence that determines the start of permanent disability, regardless of economic or vocational considerations. *Ballesteros v. Willamette W. Corp.*, 20 BRBS 184, 186 (1988). Thus, the medical evidence must establish the date on which the employee has received the maximum benefit of medical treatment such that his condition will not improve. *Trask*, 17 BRBS at 60; *Mason v. Bender Welding & Mach. Co.*, 16 BRBS 307, 309 (1984); *Rivera v. National Metal & Steel Corp.*, 16 BRBS 135, 137 (1984); *Miranda v. Excavation Constr.*, 13 BRBS 882, 884 (1981); *Greto v. Blakeslee, Arpaia & Chapman*, 10 BRBS 1000, 1003 (1979).

Here, Dr. Dellon indicated on August 25, 1998, that the Claimant had reached maximum medical improvement. Indeed, the Claimant received no further treatment from Dr. Dellon or any other physician, other than the removal of surgical wires by Dr. Dellon in September 1998. Dr. Friedman's conclusion that the Claimant had reached maximum medical improvement by the time he examined him on July 17, 2001, does not negate a finding that he reached maximum medical improvement at an earlier time. This is consistent with the lack of any treatment aimed at improving the Claimant's condition after August 1998.

I find that the Claimant reached maximum medical improvement on August 25, 1998, at which time he had received the maximum benefit of medical treatment such that his condition would not improve.

D. Section 8(f) Relief

The Employer argues that it is entitled to Section 8(f) relief because the Claimant suffered from pre-existing permanent impairments before the May 1992 and May 1994 injuries, which combined with his left arm injuries to establish his permanent partial impairment. Specifically, the Employer argues that the Claimant suffers from pre-existing degenerative spinal and neck impairment and fusion, numerous injuries and illnesses involving his right arm, a left fractured finger, hypertension, respiratory disease, and chest pain with myocardial ischemia, cardiac compression, and headaches.

The record contains, at most, only passing references to these conditions. There is no

medical evidence in the record to even suggest that any of these conditions have produced any lasting physical problems. Nor has the Employer established that the Claimant's May 1994 injury alone would not have caused his permanent partial disability.

The mere fact of a past injury does not establish disability; there must exist some serious, lasting physical problem as a result of that past injury. *Lockheed Shipbuilding v. Director, OWCP,* 951 F.2d 1143, 25 BRBS 85 (CRT) (9th Cir. 1991); *Director, OWCP v. Belcher Erectors,* 770 F.2d 1220, 17 BRBS 146 (CRT) (D.C. Cir. 1985); *CNA Ins. Co. v. Legrow,* 935 F.2d 430, 24 BRBS 202 (CRT) (1st Cir. 1991).

Dr. Meshulam did not review records from the Claimant's previous medical providers, and the several hundred pages he did review dealt primarily with the extremity injury. On his examination of the Claimant, he found no pain, stiffness, or sensitivity to cold or damp in the Claimant's neck. He noted that although the Claimant had some soreness in his neck after surgery, he returned to work without difficulty. He found that the Claimant's left finger fracture healed without residual problems. The pulmonary function tests performed by Dr. Meshulam showed moderate restrictive abnormalities; the EKG results were consistent with old myocardial infarction; and there was no evidence of acute ischemic abnormality. Dr. Meshulam concluded that the Claimant had persistent shortness of breath, and limited exercise tolerance.

Although the Claimant testified that he had previously undergone fusion of discs in his back, there are no medical records regarding this condition, or any evidence that the Claimant did not fully recover from this injury, or even suffered from chronic back pain or disc disease. Similarly, there is no medical evidence that the Claimant has serious or debilitating hypertension,[4] or respiratory or cardiac problems. Indeed, much of the evidence in the record regarding these conditions is anecdotal, and comes from the Claimant, who himself has not indicated that he has any serious, lasting physical problem as a result of any of these conditions.

Nor has the Employer established that the Claimant's May 1992 injury to his left hand produced any lasting physical problems; indeed, the evidence is to the contrary, that the Claimant had an excellent recovery from this injury. Dr. Halikman specifically stated that the Claimant's problems with his left arm were not related to his 1992 injury; the other physicians who evaluated the extent of the Claimant's disability did not relate it in any fashion to his 1992 injury. There is no evidence to indicate that the Claimant's disability is due to a combination of his 1992 and 1994 injuries.

In short, there is no evidence to support a finding that the Claimant suffered from any pre-existing condition that was such a serious disability that a cautious employer would have been motivated to discharge him. Thus, the Employer is not entitled to Section 8(f) relief.

ORDER

[4] In fact, the Claimant denied that he had hypertension.

On the basis of the foregoing, Employer shall:

A. Pay the Claimant temporary total disability compensation benefits from May 5, 1994 through August 25, 1998, based on an average weekly wage of $538.68.[5]

B. Commencing on August 25, 1998, pay to Claimant compensation for his 60 percent permanent partial disability of the left upper extremity, based upon his average weekly wage of $538.68.

C. The Employer shall receive credit for all amounts of compensation previously paid to the Claimant as a result of his left upper extremity injury.

D. Pay to the Claimant all medical benefits to which he is entitled under the Act.

E. Pay to the Claimant's attorney fees and costs to be established by a supplemental order.

F. The District Director shall perform all calculations necessary to effect this Order.

SO ORDERED.

A

LINDA S. CHAPMAN
Administrative Law Judge

[5] The parties have stipulated that the date of injury was May 20, 1994. However, that is the date that the Claimant first saw Dr. Halikman for problems with his left arm. Records from the Eastern Industrial Medical Center, as well as the Claimant's testimony, indicate that the precipitating injury occurred on May 5, 1994.